MONTANA CHEMICAL DEPENDENCY CENTER POLICY AND PROCEDURE MANUAL

Policy Subject: Seizure Protocol	
Policy Number: MNP 05	**Standards/Statutes: ARM 37.27.130**
Effective Date: 01/01/02	**Page 1 of 3**

PURPOSE:
To provide appropriate medical care to a patient experiencing a grand mal seizure.

POLICY:
In the event of a patient having a grand mal seizure, the nursing/medical staff will manage the immediate care and treatment of the patient.

PROCEDURE DURING THE SEIZURE:

I. All staff in the immediate area should respond and offer assistance. One available staff should call for medical back up in accordance to policy.

II. Available staff should instruct all other patients to leave the area and offer them reassurance, as necessary.

III. During a grand mal seizure, a patient is unconscious, thus will not feel or see anything during the seizure or remember anything about the seizure when it is over.

IV. Note the time the seizure began and monitor the length of the seizure.

V. All movements of the patient are uncontrollable. If the patient is in a chair, gently assist the patient to the floor. Try to position the patient on their side with a pillow under their head to reduce the risk of aspiration. The immediate area must be made safe. As possible, remove any furniture or other objects from the area.

VI. If possible, loosen any clothing around the patient's neck.

VII. Do not try to restrain the patient's movements. Attempts to restrain the patient could seriously hurt the patient and possibly the person attempting to do the restraining.

VIII. Do not attempt to place an object into the patient's mouth. This could injure the patient's mouth or teeth, or it could trigger the patient's gag reflex, causing the patient to vomit.

IX. During a seizure, a patient may become cyanotic. This is to be expected during the seizure because the patient is not breathing normally.

X. Aspiration can potentially happen during a seizure, thus a suction machine should be readily available.

XI. STATUS EPILEPTICUS: This is a very unlikely event to occur, but the nursing staff should know what it is and what to do in the event that it does occur. Status epileptics is prolonged seizure activity or the seizures come in rapid succession without full recovery of consciousness between seizures. This is a medical emergency. If a doctor is not immediately available, they should be notified immediately, and the Advanced Life Support Team should be initiated by dialing the emergency 911 number. The doctor may order a parental dose of a benzodiazepine before the Advanced Life Support Team arrives. Valium Injectable is found in the emergency box.

XII. PROCEDURE AFTER THE SEIZURE:

XIII. When the seizure is over, it is expected that the patient will be tired, confused, and weak. The patient may not recognize anyone or understand what is being said to him or her at first. Staff helping the patient should talk in a calm, reassuring voice. The number of staff assisting the patient should be kept to a minimum to prevent sensory overload. Touching the patient should also be kept at a minimum because this could exacerbate the patient's confusion.

XIV. Frequently at the beginning of the seizure when a patient becomes unconscious, they may hit their head. The nursing staff assisting that patient should gently check the head area for any possible contusion or laceration. First aid should be administered as necessary at the scene.

XV. As the patient begins to awaken, the patient should be reassured and assisted to the medical treatment unit for further treatment and observation. Confusion following a seizure can last anywhere from a couple of minutes to several hours.

XVI. If the doctor on call was not available in-house to respond to the seizure, they should be notified about the patient's seizure immediately. The physician will give orders for treatment, observation, and possible medication.

XVII. During the seizure, the patient may have lost control of his bladder or bowels. If this occurs, attempts to clean up the patient should be done in slow, cautious manner, explaining to the patient what is being done. The patient could still be experiencing some confusion and this could be misinterpreted as intrusive, causing the patient to become combative.

XVIII. Because the patient will have no memory of the event, it is important that the nursing staff offer the

patient support and assurance as needed.

XIX. Documentation of the event should be completed on the progress notes and a Seizure Report Form completed.

XX. The medical Administrator and the nursing supervisor will review the Seizure Report Form and make quality improvement recommendations as necessary.

Revisions:

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